



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ORTHOPAEDIC SPECIALISTS OF AUSTIN
4611 GUADALUPE STREET SUITE 200
AUSTIN TX 78751

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1114-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Proper coding of services performed."

Amount in Dispute: \$163.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Rule 133.307 indicates a request for medical fee reimbursement dispute resolution must be submitted within one year from the disputed date of service. The disputed date in this instance is 10/8/10. One year from 10/8/10 is 10/8/11. The DWC MDR date stamp on the requestor'sDWC-60 packet is 12/9/11, well past the one year prescribed by the pertinent rule."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2009	97001-GP, 97110-GP, 97010-GP, 97140, 99212, 99080-73, 99215-25, 99080-69	\$163.01	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason code:

Explanation of benefits dated November 5, 2010

- CAC-150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF

SERVICE.

- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- CAC-45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT. (USE GROUP CODES PR OR CO DEPENDING UPON LIABILITY).
- 198 – ALLOWANCE WAS REDUCED AS PER CONTRACTUAL AGREEMENT.
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 793 – REDUCTION DUE TO PPO CONTRACT. PPO CONTRACT WAS APPLIED BY FOCUS. FOR PROVIDER SUPPORT 1-800-243-2336.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. ... A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is October 8, 2010. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 9, 2011. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	January 10, 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.